DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 - 0 0 1

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
01/01/01

5. TYPE OF PLAN MATERIAL *(Check One):*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.200, 447.204, 447.230 and 447.321

7. FEDERAL BUDGET IMPACT:
a. FFY 00-01 $ 28,533
b. FFY 01-02 $ 9,417

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A, Limitation Supplement
Pages 3 & 3a

Attachment 4.19-B;
Pages 2a, 2b & 2c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable):*
Attachment 3.1-A, Limitation Supplement
Pages 3 & 3a
Attachment 4.19-B Pages 1 2a & 2b

10. SUBJECT OF AMENDMENT:
Rates for Primary Care and Pediatric Sub-specialist Providers

GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
William A. Prince

14. TITLE:
Director

15. DATE SUBMITTED:
January 16, 2001

16. RETURN TO:
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
January 25, 2001

18. DATE APPROVED:
March 16, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Crosser

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

5. Physician Services

Physician Services are limited to procedures performed, or directly supervised by a practitioner licensed by the appropriate State Board of Medical Examiners as a doctor of medicine or osteopathy. Services are further limited to those rendered by an enrolled physician provider on behalf of an eligible recipient within the designated South Carolina Service Area. All services must be medically necessary and appropriate for the diagnosis and treatment of a specified condition. Physician Services may be rendered in a physician's office, clinic, hospital, nursing home, patient's home or elsewhere.

Technical Services, including materials that are supplied by a physician in an ambulatory setting are considered part of the physician's professional service unless specifically designated as a separate service in the South Carolina Medicaid Physician, Clinical and Ancillary Services Manual.

Physician supervision is restricted to services provided under the direct supervision of a physician directing a paramedical professional or other licensed individual. The physician must be responsible for all services rendered and be accessible at all times during the diagnosis and treatment of the patient.

Primary Care Providers:

Primary Care Providers are defined as those medical personnel that provide routine or preventive care. Primary care providers include, but are not limited to, Family Practitioners, General Practitioners, Internists, Nurse Practitioners, Osteopaths, OB/GYN, and Pediatricians.

Pediatric Sub-specialist Providers:

Pediatric sub-specialists are defined as those physicians who a) in his/her practice have at least 85% of their patients who are children 18 years or younger; b) practice in the field of Adolescent Medicine, Cardiology, Cardiothoracic Surgery, Critical Care, Emergency Medicine, Endocrinology, Gastroenterology/Nutrition, Genetics, Hematology/Oncology, Infectious Disease, Nephrology, Neurology, Neurological Surgery, Opthamology, Orthopedic Surgery, Otolaryngology, Psychiatry, Pulmonology, Rheumatology, Surgery, Urology and such other pediatric sub-specialty areas as may be determined by the Department of Health and Human Services in consultation with the Children's Hospital Collaborative; and c) are affiliated through appointment, privileges or other contractual arrangement for services with a Children's Hospital/healthcare system which meets criteria for institutional or associate membership established by the National Association of Children's Hospitals and Related Institutions (NACHRI) or which is affiliated with a NACHRI qualified institution.

Ambulatory Care Examinations:

Effective October 1, 1991, Ambulatory Care Examinations are limited to twelve (12) visits per State fiscal year (July - June) per recipient. All ambulatory care examinations prior to October 1, 1991, will not count toward the twelve (12) visit limitation. Recipients under the age of 21 years are

exempt from the twelve (12) visit limitation. Ambulatory care exams include all physician office examinations for general medical diagnoses and specialty care. Included in the ambulatory care restrictions are rural health clinic encounters and initial psychiatric visits. Surgery, therapy, family planning, diagnostic tests, monitoring, and maintenance management are not included in the twelve (12) visits limitation.

Hospital Services rendered by a physician are not restricted but are subject to the pre-admission review process, medical necessity criteria and the limitations included in the hospital section of the plan.

All services listed in the Current Procedural Terminology Text (CPT), and the HCPCS Supplemental Coding Manual are allowed services unless restricted in the Medicaid Physician, Clinical and Ancillary Services Manual. These services include, but are not limited to, general medical care, diagnostic services, therapeutic services, reconstructive and medically necessary surgeries, maternal care, family planning, rehabilitative and palliative services, lab, x-ray, injectable drugs, and dispensable and supplies not restricted in other areas of the plan or the Medicaid provider manuals.

Physician Services that are specifically restricted are speech therapy. Speech and hearing examinations, physical therapy, and occupational therapy are restricted as defined in the Physician, Clinical and Ancillary Services Manual. Vision Care Services provided by a physician are restricted as defined in the Optometric section of the plan and the Vision Care Manual.

Preventive Care:

Well Baby Care is limited to routine newborn care and follow-up in the hospital. All other well baby services are limited to the provisions defined in the EPSDT section of the plan.

Immunizations are limited to those defined in the EPSDT section of the plan, except for influenza, pneumonia and hepatitis vaccinations for at risk patients as described in the Physician, Clinical and Ancillary Services Manual.

Preventive Services are further limited to specific cancer screening procedures as listed for the following at risk patients without diagnostic indicators:

1. Mammography - Baseline: age 35-39, One every other year: age 40-50, One every year: age 50-up.

2. Pap Smear - One per year: age in conjunction with onset of menses.

3. Digital Rectal Exam - One per year: age 50-up for low risk clients: age 40-up for high risk clients.

4. Hemoccult Test - One per year: age 50-up for low risk clients: age 40-up for high risk clients.

5. Sigmoidoscopy - Sponsored if either test in #3 or #4 above is positive.

Physician Therapy. Occupational Therapy and Psychological Services:

These services include physical therapy services, occupational therapy services and psychological testing, evaluation and counseling services and are reimbursed at an established fee schedule based on cost or by the methodologies set forth in other sections of the Plan.

Nursing Services for Children Under 21:

Initial reimbursement to providers of nursing services for children under the age of 21 is made on the basis of an established fee schedule not to exceed the prevailing charges in the locality for comparable services under comparable circumstances. Reimbursement will be provided on a unit of a quarter of an hour basis for skilled nursing services and a per encounter basis for medication administration and other similar procedures. The current reimbursement rates are based on rates or fees reimbursed for similar services.

State and local government providers must submit annual actual cost and service delivery data. The State shall utilize Medicare reasonable cost principles as well as OMB Circular A-87 and other OMB circulars as may be appropriate during its review of actual allowable costs. Future reimbursement rates to state and local government providers shall be the lesser of actual allowable documented cost or the established fee.

4.c Family Planning Services and Supplies:

Family Planning Services are reimbursed at an established fee schedule based on cost or by the methodologies set forth in other sections of the Plan.

5. Reimbursement for physicians, osteopaths, and podiatrists will be the amount calculated by using a State agency determined percentage of the Medicare Resource Based Relative Value System (RBRVS) Fee Schedule, or the amount calculated by using a payment schedule based upon the relative value of each procedure code multiplied by a conversion factor assigned by the State Agency, or lesser of actual charge. Relative values are based on those established for the Medicare RBRVS. For those procedures not having a relative value, reimbursement is based on data collected within the Medicaid Management Information System or by a review conducted by medical personnel to establish the relative value. The percentage and/or the conversion factor will be reviewed annually prior to the close of each State fiscal year. Updates to the payment schedule may be targeted to specific procedure codes or ranges of procedure codes. Some of the considerations for targeting updates are: ensuring provider participation, eliminating inequities with the system, ensuring providers recover out-of-pocket expenses, etc. The payment schedule is applied uniformly to all reimbursement without consideration to locality or specialty of the physician.

Effective January 1, 2001, primary care providers will receive an enhanced Medicaid rate for evaluation and management codes which include those preventive and primary care services performed by primary care providers who typically provide medical homes for their clients. These enhanced rates are established at 81.25 percent of the Medicare fee schedule rate for selected CPT codes as determined by the state agency, and will be incorporated into the agency's Physician Fee Schedule. Primary care providers include, but are not limited to, Family Practitioners, General Practitioners, Internists, Nurse Practitioners, Osteopaths, OB/GYN, and Pediatricians.

Effective January 1, 2001, pediatric sub-specialist providers will receive an enhanced Medicaid rate for evaluation & management and medical &

surgical procedure codes which includes those primary preventive, diagnostic, and treatment services that are provided to medically fragile children. These enhanced rates are established at 120 percent of the Medicare fee schedule rate for selected CPT codes as determined by the state agency, and will be incorporated into the agency's Physician Fee Schedule. Pediatric sub-specialist providers are those medical personnel that meet the following criteria: a) in his/her practice have at least 85% of their patients who are children 18 years or younger; b) practice in the field of Adolescent Medicine, Cardiology, Cardiothoracic Surgery, Critical Care, Emergency Medicine, Endocrinology, Gastroenterology/Nutrition, Genetics, Hematology/Oncology, Infectious Disease, Nephrology, Neurology, Neurological Surgery, Opthamology, Orthopedic Surgery, Otolaryngology, Psychiatry, Pulmonology, Rheumatology, Surgery, Urology and such other pediatric sub-specialty areas as may be determined by the Department of Health and Human Services in consultation with the Children's Hospital Collaborative; and c) are affiliated through appointment, privileges or other contractual arrangement for services with a Children's Hospital/healthcare system which meets criteria for institutional or associate membership established by the National Association of Children's Hospitals and Related Institutions (NACHRI) or which is affiliated with a NACHRI qualified institution.

Alternate Reimbursement Methodology (ARM)
A provider of physician's primary care services may opt to be reimbursed under the Alternate Reimbursement Methodology (ARM).

The ARM rate is based on the historical reimbursement and utilization data for the core set of primary care services including a payment for management of a recipient's health care services. The rates are set for appropriate age and sex groupings and categories of eligibility. The monthly ARM rate, for the core set of primary care services, will be reimbursed to a Medicaid provider based on the number of Medicaid recipients enrolled in the provider's practice.

The ARM rate will not exceed the upper payment limits as specified by 42 CFR 447.361. The ARM rate will not exceed the amount that can reasonably be estimated would have been paid for those same services on a fee-for-service basis to a non enrolled population group.

The ARM rate will be reviewed annually to assure reasonableness and adequacy as compared to those same services on a fee for service basis.

A **Primary Care Access Incentive Payment** to actively enrolled primary care physicians who have served a large volume of Medicaid recipients will be developed based on the volume of unduplicated recipients served by any given physician during the first three quarters of the state's fiscal year. The primary care services which the SCDHHS will use in order to determine the number of unduplicated Medicaid recipients will consist of office visits, prenatal and postpartum visits, and Early and Periodic Screening, Diagnosis and Treatment exams. The purpose of these payments will be to ensure and increase access of primary care services to Medicaid recipients. The **Primary Care Access Incentive Payment** (when added to prior payments for services rendered during the specified period) will not exceed the charges made by providers for office visits, prenatal and postpartum visits, and Early and Periodic Screening, Diagnosis and Treatment exams. The **Primary Care Access Incentive Payment** may vary from year to year when added to paid claims, but will not exceed 100% of charges. The primary care physicians targeted for these payments include the following: family physicians, general practitioners, gynecologists, internists, obstetricians, osteopaths, and pediatricians. Physicians currently practicing at a Federally Qualified Health Center or Rural Health Clinic have been excluded from these incentive payments.

For each recipient served, the primary care physicians will receive a **Primary Care Access Incentive Payment** based on the following schedule:

Payment per Recipient	Number of Recipients Served
$3.00	75 - 374
5.00	375 - 749
7.00	750 - 1,124
8.00	1,125 or more

In order to reimburse the Primary Care Access Incentive Payment, the SCDHHS will establish a pool of funds and may pay from $0 up to $1,000,000 in any given state fiscal year.